

ILLINOIS DEPARTMENT OF CORRECTIONS

Offender Medical Problem List  
STA NRC CENTER

N60788 BURT, RONALD E.

Age: 40

DOB: 01/17/1967

Race: WHI

Sex: M

NRC 01/26/2007

ID#:

Problem Number	Date Entered	Problem List	Problem Resolved	Date Resolved
1	1/21/07	NKA		
2	"	Hep C		
3	"	Scoliosis		
	4/30/08	23° blo liver lit in km		
	11/16/09	MENARD PROBLEM LIST UPDATED AS DATE 8 Int. Routine Care, No Change Additions: 1. Hg alcohol & multiple substance abuse 2. (1) knee reconstructive surgery, 1997 3. (1) Pneumothorax 1985 4. Hep. C. JH		
	2/23/11	Problem reviewed, no addition or changes JH		
		MENARD PROBLEM LIST REVIEWED Updated For: Transfer to The changes are: Hepatitis C/C		
	1/2/13	HEPC CC DONE X. Cady/K		
	6/26/13	MENARD PROBLEM LIST REVIEWED Updated For: <u>Went to return</u> The changes are: <u>Hep C C</u> Ant JH		

Distribution Offender's Medical Record

Printed on Recycled Paper

DOC 0088 (EH 9/2002)  
(Replaces DC 7141-A)

EXHIBIT

1



Date 1/31/07  
 Time 1150A ☐ a.m. ☐ p.m.  
 Offer: N60788 BURT, RONALD E.  
 Race: Age: 40 DOB: 01/17/1967  
 Race: WHI Sex: M  
 Gender: NRC 01/26/2007

Objective: System	Normal	ABN	Explanation:
Head, Neck, Face, & Scalp	/		
Nose and Sinuses	/		
Mouth and Throat	/		Oral Condition
Ears	/		Drums
Eyes	/		Pupils Accommodation: <u>firm</u> Auscultation: <u>cr</u> Fundoscopic: <u>cr</u>
Lungs and Chest including Breast	/		Rate: <u>def</u> Rhythm: <u>def</u> Size Murmurs: <u>def</u>
Heart	/		Consistency: <u>def</u> Masses: <u>def</u> Tenderness: <u>def</u> Scars: <u>def</u>
Vascular	/		Visual: <u>def</u> Digital: <u>def</u> Guaiac +/- / R <u>def</u>
Abdomen	/		Strength: <u>def</u> ROM: <u>def</u>
Anus Rectum (Prostate - 40+ Male Only)	/		Strength: <u>def</u> ROM: <u>def</u>
Genito-Urinary System	/		Strength: <u>def</u> ROM: <u>def</u>
Upper Extremities	/		Strength: <u>def</u> ROM: <u>def</u>
Lower Extremities	/		Strength: <u>def</u> ROM: <u>def</u>
Spine and Musculo-Skeletal	/		Lordosis noted C-spine / curvature T-spine Slight
Skin and Lymphatics	/		
Neurologic DTR's	/		Romberg: Biceps: Patella:
Mental Status	/		
Pelvis (Female Only)			Cervix: Fundus: Vaginal Canal: PAP: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> R

Assessment: Problem #

1. NKA  
 2. Hep  
 3. Schizophrenia

Plan: Check boxes appropriate and complete plan:

Placement Consideration: ☐ Yes ☒ No  
 HR: ☐ Yes ☒ No

Food Handler Status:  
 1. monitor from 1/31/07 to 2/1/07  
 2. refer to Hepatitis clinic  
 3. education SKE / health  
 exam / exercise / diet

Examiner's Signature:

L. Wms, pae  
 R. Wms, pae  
 L-3107

Distribution: Offender's Medical Record

Side 2  
 Printed on Recycled Paper

DOC 0069 (Eff 9/2002)  
 (Replaces DC 672)



ILLINOIS DEPARTMENT OF CORRECTIONS  
Offender Health Status Transfer Summary

Transferring Facility:

STATEVILLE NRC Center

Offender Information:

Burt  
Last Name

Ronald  
First Name

MI

ID#: N60785

Date: 6/19/07 Time: ☐ a.m. ☐ p.m.

Transfer Screening (completed by transferring facility health care staff):

Allergies: NKA Food Handler Approved: \_\_\_\_\_

Current / Acute Conditions / Problems:

Chronic Conditions / Problems: Schizophrenia, Myocardial

Current Medications (name, dosage, frequency, and duration):

Acute Short-term:

Chronic Long-term:

Chronic Psychotropic:

Motilon 400mg P.O. TID x 3 months

Current Treatments:

Therapeutic Diets:

Follow-Up Care:

Chronic Clinics: HR

Specialty Referrals:

Significant Medical History:

HepC Myocardial Schizophrenia

Physical Disabilities / Limitations:

Assistive Devices / Prosthetics:

Medical Health Issues: ☐ Hx Suicide Attempt Date: \_\_\_\_\_

☐ Hx Psych Med

☐ Hx MPC / STC

Substance Abuse:

☐ Glasses ☐ Dentures

☐ Alcohol ☐ Drugs

LAB

EKG

CXR

Dental

MEDS

IMH

Other

☐ Packet Complete

Print Name and Title

Signature

Date

Reception Screening (completed by receiving facility health care staff):

Facility:

Date:

Time:

☐ a.m.

☐ p.m.

Subjective:

Current Complaint:

Assessment:

Current Medications/Treatment:

Objective:

Physical Appearance/Behavior:

Plan: Disposition:

☐ Health Information Given

☐ Emergency Referral:

☐ Sick Call: Urgent / Routine

☐ Medication Evaluation

☐ Therapeutic Diet

☐ Special Housing

☐ Chronic Clinics

☐ Work / Program Limitation

☐ Specialty Referrals

☐ Other (specify):

☐ Infirmary Placement:

☐ Other (specify):

T:

P:

R:

B/F:

Printed Name and Title

Signature

Date

For adult transition center transfers only:

I understand that medical and dental care are my responsibility while I am housed in a transition center. I also understand that if I am in need of health care and I cannot afford to pay for it, I may be transferred back into a facility within the Department that can provide my medical, mental health, or dental needs.

☐ a.m. ☐ p.m.

Location: Offender's Medical Record; Transferring Facility;  
Receiving Facility

Printed on Recycled Paper

DOC 0090 (Eff. 9/2002)  
(Replaces DC 873)

MEN 01500

BURT SELECTED (MR) 0004



ILLINOIS DEPARTMENT OF CORRECTIONS

Offender Outpatient Progress Notes

Stateville Correctional Center

Offender Information:

Burt

Russell

ID#: 260784

Last Name

First Name

MI

Date/Time	Subjective, Objective, Assessment	Plans
9/2/07	PA NOTE	1. Motrin 400mg po
9 <sup>th</sup> A.	40 y/o w/m c/o scoliosis	2. pain pain x 4 times
	now has pain in neck and	2. pt education /
145 1/2 lbs	middle part of his back	reassurance
72"	Just arrived here from NRE	3. RTC per
130/94	Pain has been going on for past	
101. PR	45 yrs pretty consistently	
	Was seen 2 days ago for	
	Physical exam and hasn't	
	received motrin yet. Had	
	to sleep	
	D = gen = mlt	
	H/L = mlt	
	Ext = C-spine c lordosis noted	
	to palp paraspinal musculature	
	and + spine c prominence and	
	paraspinal musculature to palp	

ILLINOIS DEPARTMENT OF CORRECTIONS

Distribution: Offender's Medical Record

DOC 0084 (Eff. 9/2002  
(Replaces DC 7147)

1 = musculoskeletal pain  
2 = scoliosis

MEN 01499

BURT SELECTED (MR) 0005

ILLINOIS DEPARTMENT OF CORRECTIONS  
Offender Health Status Transfer Summary

Transferring Facility:

Stateville Correctional Center

Offender Information:

BURT

RONALD

ID#: N60788

Date: 1, 2, 08

Time: 1:30

☐ a.m. ☒ p.m.

Transfer Screening (completed by transferring facility health care staff):

Allergies: NKA

Food Handler Approved:

Current / Acute Conditions / Problems:

Chronic Conditions / Problems: HEP C SCOLIOSIS

Current Medications (name, dosage, frequency, and duration):

Acute Short-term:

Chronic Long-term:

Chronic Psychotropic: motrin 400mg po tid

Current Treatments:

Therapeutic Diets: RBC

Follow-Up Care: R. HC

Chronic Clinics: High Risk

Specialty Referrals: X

Significant Medical History: HEP C, migraines, scoliosis

Physical Disabilities / Limitations: X

Assistive Devices / Prosthetics: X

☐ Glasses

☐ Dentures

Mental Health Issues: ☐ Hx Suicide Attempt Date: / /

☐ Hx Psych Med

☐ Hx MPC / STC

Substance Abuse:

☐ Alcohol

☐ Drugs

R & C Use Only:

☐ LAB

☐ EKG

☐ CXR

☐ Dental

☐ MEDS

☐ MH

☐ Other:

☐ Packet Complete

Ks Brown

Print Name and Title

[Signature]

Signature

1, 2, 08

Date

Reception Screening (completed by receiving facility health care staff):

Facility:

Date: / /

Time: / /

☐ a.m.

☐ p.m.

Subjective:

Current Complaint:

Current Medications/Treatment:

Objective:

Physical Appearance/Behavior:

Deformities: Acute/Chronic:

T:

P:

R:

B/P:

/

Assessment:

Plan: Disposition:

☐ Health Information Given

☐ Emergency Referral:

☐ Sick Call: Urgent / Routine

☐ Medication Evaluation

☐ Therapeutic Diet

☐ Special Housing

☐ Chronic Clinics

☐ Work / Program Limitation

☐ Specialty Referrals

☐ Other (specify):

☐ Infirmary Placement:

☐ Other (specify):

Printed Name and Title

Signature

Date

For adult transition center transfers only:

I understand that medical and dental care are my responsibility while I am housed in a transition center. I also understand that if I am in need of health care and I cannot afford to pay for it, I may be transferred back into a facility within the Department that can provide my medical, mental health, or dental needs.

Offender's Signature

Date

Time

☐ a.m. ☐ p.m.

Distribution: Offender's Medical Record; Transferring Facility;

DOC 0090 (Eff. 9/2002)

MEN 01505

BURT SELECTED (MR) 0006



ILLINOIS DEPARTMENT OF CORRECTIONS  
Offender Health Status Transfer Summary

Transferring Facility:  
STA-NRC CENTER

Offender Information:  
Last Name: Burt First Name: Ronald MI: N60788

Date: 1/28/08 Time: \_\_\_\_\_ ☐ a.m. ☐ p.m.

Transfer Screening (completed by transferring facility health care staff):

Allergies: \_\_\_\_\_ Food Handler Approved: \_\_\_\_\_

Current / Acute Conditions / Problems: \_\_\_\_\_

Chronic Conditions / Problems: Hep CT / Schistos

Current Medications (name, dosage, frequency, and duration): \_\_\_\_\_

Acute Short-term: Motrin 400mg TID PRN

Chronic Long-term: \_\_\_\_\_

Chronic Psychotropic: \_\_\_\_\_

Current Treatments: 0

Therapeutic Diets: Regular diet

Follow-Up Care: F/O PD

Chronic Clinics: high risk clinic

Specialty Referrals: 0

Significant Medical History: 0

Physical Disabilities / Limitations: my Migraines, Schistos

Assistive Devices / Prosthetics: \_\_\_\_\_

Mental Health Issues: ☐ Hx Suicide Attempt Date: \_\_\_\_\_ ☐ Hx Psych Med ☐ Hx MPC / STC Substance Abuse: ☐ Alcohol ☐ Drugs

R & C Use Only: ☐ LAB ☐ EKG ☐ CXR ☐ Dental ☐ MEDS ☐ MH ☐ Other: \_\_\_\_\_ ☐ Packet Complete

Print Name and Title: Joseph Asenbino Signature: [Signature] Date: 1/28/08

Reception Screening (completed by receiving facility health care staff):

Facility: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_ ☐ a.m. ☐ p.m.

Subjective: \_\_\_\_\_ Assessment: \_\_\_\_\_

Current Complaint: \_\_\_\_\_

Current Medications/Treatment: \_\_\_\_\_

Objective: \_\_\_\_\_

Physical Appearance/Behavior: \_\_\_\_\_

Deformities: Acute/Chronic: \_\_\_\_\_

T: \_\_\_\_\_ P: \_\_\_\_\_ R: \_\_\_\_\_ B/P: \_\_\_\_\_

Plan: Disposition: ☐ Health Information Given ☐ Emergency Referral: \_\_\_\_\_

☐ Sick Cell: Urgent / Routine

☐ Medication Evaluation ☐ Therapeutic Diet ☐ Special Housing ☐ Chronic Clinics

☐ Work / Program Limitation ☐ Specialty Referrals ☐ Other (specify): \_\_\_\_\_

☐ Infirmary Placement

☐ Other (specify): \_\_\_\_\_

Printed Name and Title: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

For adult transition center transfers only:

I understand that medical and dental care are my responsibility while I am housed in a transition center. I also understand that if I am in need of health care and I cannot afford to pay for it, I may be transferred back into a facility within the Department that can provide my medical, mental health, or dental needs.

Offender's Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_ ☐ a.m. ☐ p.m.

Distribution: Offender's Medical Record; Transferring Facility;

DOC 0090 (Eff. 9/2002)

MEN 01506

BURT SELECTED (MR) 0007

ILLINOIS DEPARTMENT OF CORRECTIONS

Offender Outpatient Progress Notes

Menard Cor Center

Offender Information:

Burt  
Last Name

Ronald  
First Name

Mi

N 60788

ID#:

Date/Time	Subjective, Objective, Assessment	Plans
1-29-08 9 <sup>00</sup> P	CMT Note 3) Arrived / transferred to Menard Correctional Center this pm.	P) Refer to MO/ NP - chart to arrive 1-30-08 per Stateville staff.
114/76 76-16 98 <sup>8</sup>	0) Medical file not sent with patient. Health Status shows Hyp C+ (High Risk Chronic Clinic). Patient relates a history of scoliosis and with that frequent back pain.	
	A) Hyp C+ & Scoliosis	D. Brown cat.

Distribution: Offender's Medical Record

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DOC 0084 (Eff. 9/2002  
(Replaces DC 7147)

MEN 01508

BURT SELECTED (MR) 0008



ILLINOIS DEPARTMENT OF CORRECTIONS

Offender Outpatient Progress Notes

Menard Center

Offender Information:

Burt

Last Name

Ronald

First Name

MI

ID#: N60788

Date/Time	Subjective, Objective, Assessment	Plans
2/4/08	<u>NP Note</u>	P: Schedule to
2:00p	S: Scheduled for transfer in evaluation. W/m Hep C+ D/A T/m was in process of being worked up for HCV+ tx. no biopsy on tx currently. W/m not seen.	Dr. Sinnerman or R. Pillion for evaluation for Hep C tx. K. Cross, cnt K. Weiss, cnt
2/7/08	<u>NP Note</u>	P: add to Gentle
1:10p	S: Scheduled for eval Hep C. S/R was being worked up for HCV tx. Has life sentence. Also c/o scoliosis	cc Explained to T/m will monitor LFTs
Request Mettin	O: Labs - AST - 27 } 10/07 ALT - 37	g 4mms c cc Obtain old volumes
	Viral load 2269500 ↓ from 3538850 10/07 6/07	for X-ray report of back
	A. HCV c	Mettin 400mg po tid po x 30 days
	S/R scoliosis	<u>Q. Fuller</u>

Distribution: Offender's Medical Record

Printed on Recycled Paper

DOC 0084 (Eff. 9/2002  
(Replaces DC 7147)

MEN 01509

BURT SELECTED (MR) 0009

ILLINOIS DEPARTMENT OF CORRECTIONS  
Offender Health Status Transfer Summary

Referring Facility:

Menard Center

Offender Information:

Dort Ronald ID#: 060788  
Last Name First Name MI

Date: 1/24/09 Time: 1205 ☒ a.m. ☐ p.m.

Transfer Screening (completed by transferring facility health care staff):

Allergies: NIL Food Handler Approved: 1/31/07 AFH

Current / Acute Conditions / Problems: 6

Chronic Conditions / Problems: HCV

Current Medications (name, dosage, frequency, and duration):

Acute Short-term: 6

Chronic Long-term: 6

Chronic Psychotropic: 6

Current Treatments: 6

Therapeutic Diets: 6

Follow-Up Care: 6

Chronic Clinics: HCV

Specialty Referrals: 6

Significant Medical History: HCV - treatment failure, Hx ill. hip/knee pain, Hx ht. pneumonia, Hx ht. surgery, Hx knee surgery, Hx myocardial infarction

Physical Disabilities / Limitations: 6

Assistive Devices / Prosthetics: 6 ☐ Glasses ☐ Dentures

Mental Health Issues: ☐ Hx Suicide Attempt Date: 1/1 ☐ Hx Psych Med ☐ Hx MPC/STC Substance Abuse: ☐ Alcohol ☐ Drugs

R & C Use Only: ☐ LAB ☐ EKG ☐ CXR ☐ Dental ☐ MEDS ☐ MH ☐ Other: ☐ Packet Complete

Dana M. Gaudin Signature 1/24/09 Date

Reception Screening (completed by receiving facility health care staff):

Facility: STA CC Date: 2/3/09 Time: ☐ a.m. ☐ p.m.

Objective: Needs Hep C Assessment: 6 LFTs

Current Complaint: TEST PER PREVIOUS INST 6 DIRECTION

Current Medications/Treatment: 6 R.H. APPROVED

Objective: ALFAT X3, COUPENAT

Physical Appearance/Behavior: AMBULATORY

Deformities: Acute/Chronic: 6

Plan: Disposition: ☒ Health Information Given ☐ Emergency Referral: 6

☒ Sick Call: Urgent / Routine ☐ Medication Evaluation ☐ Therapeutic Diet ☐ Special Housing ☐ Chronic Clinics

☐ Work / Program Limitation ☐ Specialty Referrals ☐ Other (specify): 6

☐ Infirmary Placement: 6

☒ Other (specify): HEP C CLINIC

96.6 P: 96 R: 20 B/P: 133/88

GARY DRUPLIN Signature 2/3/09 Date

For adult transition center transfers only:

I understand that medical and dental care are my responsibility while I am housed in a transition center. I also understand that if I am in need of health care and I cannot afford pay for it, I may be transferred back into a facility within the Department that can provide my medical, mental health, or dental needs.

Offender's Signature Date Time ☐ a.m. ☐ p.m.

Distributor: Offender's Medical Record; Transferring Facility; Receiving Facility

Printed on Recycled Paper

DOC-0090 (Eff. 9/2002)  
(Replaces DC 873)

MEN 01541

BURT SELECTED (MR) 0010



ILLINOIS DEPARTMENT OF CORRECTIONS  
Offender Outpatient Progress Notes

STA

Center

Offender Information:

Burt

Ronald

ID#: N60788

Last Name

First Name

MI

Date/Time	Subjective, Objective, Assessment	Plans
5/12/17	6 <sup>55</sup> pm. PA NOTE A sent note stating he has HCV, and hasn't received follow up, and didn't get dentures from menard before shipment A = 1. HCV = failed tx. MD note	1. Refer to chronic dental clinic & Dental Dope
5/13/17	S: Back pain after a fall	P1. Monitor for 30
10/35A	D: OX3 RAD P2RR LABOUR	7th pm #6.
	Back no bony deformity	2. T-Spine
	NO Bruise. slight red	3. ice 2x today.
	Rom guarded	on back
	Weak Rom FALL	
	gait steady CNS intact	
	A Back injury	for MD LPN OK

Distribution: Offender's Medical Record

Printed on Recycled Paper

DOC 0084 (Eff. 9/2002  
(Replaces DC 7147)

MEN 01542

BURT SELECTED (MR) 0011

ILLINOIS DEPARTMENT OF CORRECTIONS

Offender Injury Report

Offender Name: Burt, Ronald ID#: N60788

Age: 42 Date of Birth: 1-17-67 Sex: M Race: White

Date of Injury: 5-13-09 Time of Injury: 9:45 ☒ am ☐ pm Location: \_\_\_\_\_

How did the injury occur? I Slipped on the floor it was a puddle  
of water I injured my neck & back

Was it witnessed by staff? ☒ No ☐ Yes (If yes, please list names)

Location in facility:

- ☒ LTA (gym, basketball, football, etc.)  
☐ Group (therapy)  
☐ Housing Unit (cell, dayroom, tv room, etc.)  
☐ School (classroom, library)  
☐ Kitchen  
☐ Other \_\_\_\_\_

Type of Injury:

- ☒ Sports  
☐ Assault  
☐ Job Related  
☐ Non-job Related  
☐ Self-inflicted  
☐ Fight

R. Thompson  
Signature

CMT  
Title

5-13-09  
Date

(Medical Report on Reverse Side)

Distribution Offender Medical File

Distribution Reverse Side Page 1

DOC 0313 (Rev. 07/2006)  
BUREAU OF CORRECTIONS



Offender Name Burt, Ronald ID#: N 60788

Date of medical examination: 5-13-09 Time: 9:45 ☒ am ☐ pm Physician Contacted: ☒ Yes ☐ No

S (Subjective Findings): Slipped on floor injured back & neck

O (Objective Findings): pt is A x O x 3 pt seem to have difficulty walking  
no injury seen no laceration, no bruise

Vitals: T 97.8 P 92 R 18 BP 133/91 Tetanus \_\_\_\_\_

Back no deformity no bruise slight red.

Neck Rom full.

gait steady

CNS intact.

A (Evaluation of Injury): Painful low Back Pain & Neck

P (Treatment and Follow-up): Sent to E.R for Medical Evaluation by  
wheelchair mother Guy POKU ~ 1st PM  
X ray ? spine

Disposition of patient:

☐ Return to assignment ☒ Housing Unit ☐ Lay in ☐ Infirmary ☐ Segregation  
☐ Off-site referral for treatment (Destination) \_\_\_\_\_

Print Name of Person Completing Form

Signature

Title

Date

To Be Completed By Physician

I have reviewed this report and would like to see this offender: ☒ Immediately ☐ Next Sick Call ☐ PRN

L TUNG ZHANG MD  
Print Physician Name

[Signature]  
Physician's Signature

5/13/09  
Date

Sid: 2

Distribution: Offender Medical File

(Revised on 06/01/09)

DOC 0313 (Eff. 07/2006)  
(Replaces DOC 5711-1-1)

GA

E 706

Stateville NRC

FOR X-RAY TECH ONLY

STATE OF ILLINOIS - DEPARTMENT OF CORRECTIONS

X - RAY REPORT

Stateville NRC

Inmate's Name: Burt, Ronald Number: N60788 Date: 7/18/14

Age: 42

Reason for X-Ray: T-spine

fall

Dr. Zhang

Ordering Physician

Findings:

Neg.

Date: \_\_\_\_\_

FOR CORRECTIONAL CENTER HEALTH CARE UNIT PERSONNEL ONLY

☒ I have reviewed the recommendations contained in this report.

Date: 7/20/14

Pb  
Signature and Title

IL 426 - 18393 DCA 42066

MEN 00695

BURT SELECTED (MR) 0014





ILLINOIS DEPARTMENT OF CORRECTIONS  
Offender Health Status Transfer Summary

Transferring Facility:

Stateville Correctional Center

Date: 2, 22, 10

Time: ☐ a.m. ☐ p.m.

Offender Information:

Last Name: Burt

First Name: Ronald

MI:

ID#: N60788

Transfer Screening (completed by transferring facility health care staff):

Allergies: N/A

Food Handler Approved:

Current / Acute Conditions / Problems:

Chronic Conditions / Problems:

Current Medications (name, dosage, frequency, and duration):

Acute Short-term:

Chronic Long-term:

Chronic Psychotropic:

Current Treatments:

Therapeutic Diets:

Follow-Up Care:

Chronic Clinics:

Specialty Referrals:

Significant Medical History:

Physical Disabilities / Limitations:

Assistive Devices / Prosthetics:

Mental Health Issues: ☐ Hx Suicide Attempt Date: / /

☐ Hx Psych Med

☐ Hx MPC / STC

Substance Abuse: ☐ Alcohol ☐ Drugs

R & C Use Only: ☐ LAB ☐ EKG ☐ CXR ☐ Dental ☐ MEDS ☐ MH ☐ Other:

☐ Packet Complete

Print Name and Title: A Bacot LPN

Signature: A Bacot LPN

Date: 2, 22, 10

Reception Screening (completed by receiving facility health care staff):

Facility: Menard Co. Center

Date: 2, 23, 10

Time: 4:45 p.m.

Subjective:

Current Complaint: spine curvature

Assessment:

stable

Current Medications/Treatment:

none

sp procedure undiagnosed

sp PRN

Objective:

Physical Appearance/Behavior: AXO X3

Plan: Disposition:

☒ Health Information Given

☒ Emergency Referral: 9/PRN

☒ Sick Call: Urgent / Routine

☐ Medication Evaluation

☐ Therapeutic Diet

☐ Special Housing

☐ Chronic Clinics

☐ Work / Program Limitation

☐ Specialty Referrals

☐ Other (specify):

☐ Infirmary Placement

☐ Other (specify):

sp PRN

T: 98

P: 74

R: 14

B/P: 128 / 72

Printed Name and Title: Janet Braun Cdt

Signature: Janet Braun Cdt

Date: 2, 23, 10

For adult transition center transfers only:

I understand that medical and dental care are my responsibility while I am housed in a transition center. I also understand that if I am in need of health care and I cannot afford to pay for it, I may be transferred back into a facility within the Department that can provide my medical, mental health, or dental needs.

Offender's Signature

Date

Time

☐ a.m. ☐ p.m.

Distribution: Offender's Medical Record; Transferring Facility;

DOC 0090 (Eff. 9/2002)

MEN 01555

BURT SELECTED (MR) 0016





ILLINOIS DEPARTMENT OF CORRECTIONS  
Offender Outpatient Progress Notes  
Stateville Correctional Center

B-808

Offender Information:			
Burt	Ronald	E	ID#: NC0788
Last Name	First Name	Mi	

Date/Time	Subjective, Objective, Assessment	Plans
8-16-11	CMT Note:	P/D mpse scheduled
11 <sup>00</sup> pm	S)N/C	on 8-24-11
	O) Counselor brings grievance about inmates scoliosis and exercises given causing more pain.	
	A) Pains in back	
08/24/11	PA NOTE Almond says I have calcium deficiency	
10 <sup>15</sup> Am	44ylo term on mpse c.	1. motion tomg +
3.P-118/78	cla pain all the time 2° to the scoliosis. "I want it fixed". "Hd been 10yrs. now."	or 11g8° per. #30
P-68/7m		x3ms
R-16/7m		2. A-Salm to AA
	O=gen=mt, mad, ambulator fine	3. 10/10 per. X1mb
	HL=mt-	3. 1/2 to AA. up
	EXA-M-S.=wml.	to TID
	A=1 Act in comfort neck.	4. RTU per.
		5. total to review old file

Distribution: Offender's Medical Record

Noted  
Just seen  
11-11

b. Advised calcium  
levels were low

MEN 01561



ILLINOIS DEPARTMENT OF CORRECTIONS  
Offender Health Status Transfer Summary

Transferring Facility:

S T A - N R C

Center

Offender Information:

Burt

Last Name

Ronald

First Name

MI

ID# A600788

Date: 1, 24, 12

Time: 1:00

☐ a.m. ☒ p.m.

Transfer Screening (completed by transferring facility health care staff): ☐ HIV Test & Counseling Offered (only transfers to ATC, parole, release or discharge)

Allergies: NKA

Food Handler Approved: yes

Current / Acute Conditions / Problems:

Chronic Conditions / Problems: Hep C

Current Medications (name, dosage, frequency, and duration):

Acute Short-term:

Chronic Long-term: Motrin 400mg T-ID 80

Chronic Psychotropic:

Current Treatments:

Therapeutic Diets:

Follow-Up Care:

Chronic Clinics: Hep C

Specialty Referrals:

Significant Medical History: (2) knee reconstructive surgery 1997, (2) pneumothorax 1985, scoliosis

Physical Disabilities / Limitations:

Assistive Devices / Prosthetics:

Mental Health Issues: ☒ Hx Suicide Attempt Date 1/24/12

1984

☒ Hx Psych Med

☐ Hx MPC / STC

Substance Abuse: ☒ Alcohol

☒ Drugs

☒ Glasses

☒ Dentures

Heidi Moss RN sup

Print Name and Title

H. Y. Moss RN sup

Signature

1, 24, 12

Date

Reception Screening (completed by receiving facility health care staff):

Facility:

Date:

Time:

☐ a.m.  
☐ p.m.

Subjective:

Assessment:

Current Complaint:

Current Medications/Treatment:

Objective:

Physical Appearance/Behavior:

Deformities: Acute/Chronic:

T:

P:

R:

B/P:

Plan: Disposition:

☐ Health Information Given

☐ Emergency Referral:

☐ Sick Call: Urgent / Routine

☐ Medication Evaluation

☐ Therapeutic Diet

☐ Special Housing

☐ Chronic Clinics

☐ Work / Program Limitation

☐ Specialty Referrals

☐ Other (specify):

☐ Infirmary Placement:

☐ HIV Test & Counseling Offered (only transfers from R&C)

☐ Other (specify):

Printed Name and Title

Signature

Date

For Adult Transition Center transfers only:

I understand that medical and dental care are my responsibility while I am housed in a transition center. I also understand that if I am in need of health care and I cannot afford to pay for it, I may be transferred back into a facility within the Department that can provide my medical, mental health, or dental needs.

Offender's Signature

Date

Time

☐ a.m. ☐ p.m.

Distribution: Offender's Medical Record; Transferring Facility;  
Receiving Facility

DOC 0090 (Rev. 1/2006)

MEN 01568

BURT SELECTED (MR) 0019

ILLINOIS DEPARTMENT OF CORRECTIONS

Offender Medical History

Stateville Correctional Center

- ☐ Reception History  
☐ Periodic History

Date: 3.1.12

Time: 11 ☒ a.m. ☐ p.m.

Offender Information:

Burt Ronald ID#: N60788  
 Last Name First Name MI  
 Race: ☒ White ☐ African American ☐ Asian American ☐ Hispanic ☐ Native American ☐ Other  
 Gender: ☒ Male ☐ Female Date of Birth: 01.17.1967

Subject:	Past Medical History / History of Present Illness / Family History		
Condition	Yes	No	Explanation
Allergies	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	Chronic skin rash.
Smoking	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
Pediculosis	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
Seizures	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
Asthma	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
Cardiac/HTN	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
Diabetic	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
Communicable Disease			
a. Hepatitis/Jaundice	<input checked="" type="checkbox"/>	<input type="checkbox"/>	HEP C+ Since 1999. Prior partial α-IFN tx.
b. Hx + PPD/Active TB	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
c. STD	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
d. HIV +/AIDS	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
Surgeries	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Knee @ 9/6/11 Lung 187
Hx of Psych Tx	<input checked="" type="checkbox"/>	<input type="checkbox"/>	last approx 30 yrs ago
a. Past Suicide Attempt	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
b. Current Suicidal Ideation	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
Recent Drug/ETOH use	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
Mobility Problems			
a. Assistive Devices	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
b. Prosthetics	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
c. Specialized Equipment	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
Other Medications	<input checked="" type="checkbox"/>	<input type="checkbox"/>	1ibu for neck/back pain
History of Sexual Abuse or Predator	<input type="checkbox"/>	<input type="checkbox"/>	
Oriented x3	<input type="checkbox"/>	<input type="checkbox"/>	
Other:	<input checked="" type="checkbox"/>	<input type="checkbox"/>	spinal scoliosis

Objective: T: 97.6 P: 78 ☐ regular ☐ irregular R: 16 ☐ regular ☐ irregular B/P: 128/86  
 Height: 6'3" Weight: 156.9 Vision: RT 20/ Vision: LT 20/ Corrected: RT 20/ Corrected: LT 20/  
 Behavioral appearance and mental status, Evidence of deformity, trauma, and skin conditions.

Assessment: Hep C +  
Incarcerated x 20 yrs  
Chronic allergic itching  
Fasting hypoglycemia  
 Plan: (Check and complete as appropriate)  
 1. Physical Examination: ☐ Urgent ☐ Routine  
 2. Mental Health Referral: ☐ Urgent ☐ Routine  
 3. Health Information Given: ☐ Yes ☐ Refused  
 4. PPD Results: ☐ Positive ☐ Negative  
 5. Chest X-ray performed: ☐ N/A ☐ Yes ☐ No  
 6. Other:

Date PPD Administered: / / Date PPD Read: / /  
 Reading: mm By: K. Morgan RN K Morgan RN  
 Print Name of Interviewer Signature

R & C Use Only  
 LAB: Sickie Cell: ☐ Yes ☐ No Dental: Panorex:  
 EKG: CXR: Female Only: PAP: Mamo:

Distribution: Offender's Medical Record

DOC 0092 (Eff. 9/2002)

MEN 01489

BURT SELECTED (MR) 0020



ILLINOIS DEPARTMENT OF CORRECTIONS  
Offender Health Status Transfer Summary

Transferring Facility:

S T A - N R C

Center

Offender Information:

Burt

Last Name

Ronald

First Name

MI

ID# N60788

Date:

4.16.12

Time:

1:40

☐ a.m. ☒ p.m.

Transfer Screening (completed by transferring facility health care staff): ☐ HIV Test & Counseling Offered (only transfers to ATC, parole, release or discharge)

Allergies: NKA

Food Handler Approved: Yes

Current / Acute Conditions / Problems:

Chronic Conditions / Problems: hep C ⊕, Chronic urticaria

Current Medications (name, dosage, frequency, and duration):

Acute Short-term:

Chronic Long-term: Lubriderm lotion + tube per month

Chronic Psychotropic:

Current Treatments:

Therapeutic Diets:

Follow-Up Care:

Chronic Clinics:

Specialty Referrals:

Significant Medical History: ⊕ Knee reconstruction 1997, Scoliosis, ⊕ pneumothorax 85'

Physical Disabilities / Limitations:

Assistive Devices / Prosthetics:

Mental Health Issues: ☒ Hx Suicide Attempt: Date: 1/84

☒ Hx Psych Med

☐ Hx MPC / STC

☒ Glasses

☐ Dentures

Substance Abuse: ☒ Alcohol ☒ Drugs

Heidi Moss RN sup H. Massen RN sup

Print Name and Title

Signature

Date

4.16.12

Reception Screening (completed by receiving facility health care staff):

Facility:

MCC

Date:

4.17.12

Time:

6:45

☐ a.m.

☒ p.m.

Subjective:

Current Complaint: ⊕ voiced

Assessment:

1) A/O x 3 got steady

2) NKA

3) placed on Hepatitis C/L

Current Medications/Treatment: as noted above

Objective:

Physical Appearance/Behavior:

WNL

Deformities: Acute/Chronic:

⊕ noted

T:

98°

P:

74

R:

18

B/P:

120 / 76

Plan: Disposition:

☒ Health Information Given

☐ Emergency Referral:

☒ Sick Call: Urgent ☒ Routine

☐ Medication Evaluation

☐ Therapeutic Diet

☐ Special Housing

☐ Chronic Clinics

☐ Work / Program Limitation

☐ Specialty Referrals

☐ Other (specify):

☐ Infirmary Placement

☐ HIV Test & Counseling Offered (only transfers from R&C)

☒ Other (specify): Verbalizes understanding NIS/L

Chad Friedlich RN

Printed Name and Title

Signature

Date

4.17.12

For Adult Transition Center transfers only:

I understand that medical and dental care are my responsibility while I am housed in a transition center. I also understand that if I am in need of health care and I cannot afford to pay for it, I may be transferred back into a facility within the Department that can provide my medical, mental health, or dental needs.

Offender's Signature

Date

Time

☐ a.m. ☐ p.m.

Distribution: Offender's Medical Record; Transferring Facility;  
Receiving Facility

DOC 0090 (Rev. 1/2006)

MEN 01565

BURT SELECTED (MR) 0021



ILLINOIS DEPARTMENT OF CORRECTIONS  
Offender Outpatient Progress Notes

MENARD C Center

Offender Information:

BURT

Last Name

Ronald

First Name

E

MI

ID#: N60788

Date/Time	Subjective, Objective, Assessment	Plans
11/3/12	MD NOTES	
10:15 AM	FR for continuation of Motrin analgesics for alleged back pain only	Xray of <sup>Thoraco-Lumbar/</sup> <del>Lumbar</del> Sacral Spine.
	D Scoliosis and Lubaderm lotion for alleged chronic allergic urticaria	Lubaderm lotion T tube/mouth x 6 months
	No evidence of recent Xray of spine to show Scoliosis of spine. Pt however	<del>Flu 3 weeks</del> Motrin 400mg po tid with meals x 3 weeks
	has Hep C and is on Conservative Flu protocol.	Flu for re-assessment in 3 weeks
		S. NWAOBASI, MD
		<i>[Signature]</i>
		<i>[Signature]</i> 10:40 AM
11/7/12	MD NOTES	
10:35 AM	Recent Xray of L4/S1 Spine shows no evidence of Scoliosis	DC Xray of L4/S1 Spine.
		S. NWAOBASI, MD
		<i>[Signature]</i>

ILLINOIS DEPARTMENT OF CORRECTIONS

Offender Outpatient Progress Notes

Menard Correctional Center

Offender Information:

Burt  
Last Name

Ronald  
First Name

E.  
MI

ID#: 1160788

Date/Time	Subjective, Objective, Assessment	Plans
12/1/12	MD NOTES	
10:15 AM not 1451b BP 120/80	S: Came for F/U of visit of 11/03/12	X-ray of Cervical Spine PA Lateral
P 80 R 16 T 98.0 F	O: Hx of Cervical spine pain not the L5 spine. No recent Xrays of Cervical spine to assess the degree of Scoliosis No clinical hx of parasthesia	Metrix 600mg po tid with meals x 2 months F/U 2 months
	A: Possible Degenerative Osteoarthritis of Cervical spine ? Scoliosis of spine	S. NWAOBASI, MD 12/1/12 meakley C. M.D. Noted at 10:30 AM
12/5/12	X-RAY TECH. NOTE X-RAY DONE	
9 A	Cervical spine	Bluyett R
12/5/12	LAB NOTE	
9:10 A	CLINICAL COMMENT HCV 12/1/12 male	

Distribution: Offender's Medical Record

Printed on Recycled Paper

DOC 0084 (EFF. 8/2002)  
(Replaces DC 7147)

MEN 01577

BURT SELECTED (MR) 0023



OneRadiology  
Normal, IL 61761  
Date: December 6, 2012

Patient: Burt, Ronald  
ID#: N60788  
DOB: 1/17/67  
Ordered by: Dr. Nwaobasi  
Menard Correctional Center

CERVICAL SPINE THREE VIEWS 12/5/2012


HISTORY: Chronic pain.

FINDINGS: There is narrowing of the disc at C4-C5 level suggestive of degenerative process.

The precervical soft tissues are not thickened and there is no gross evidence of an acute regional bony fracture or dislocation.

The trachea is midline.

Signed

  
N. Yousuf, M.D.

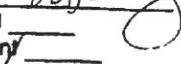
NY:eg  
DIC: 12/6/2012  
Films from Menard Correctional Center

Received  
12-11-12

M D Review

Date 12/11/12

Doctor 

Pull Chart 

See Patient 

File 

jm

OneRadiology  
Normal, IL 61761  
Date: December 6, 2012

Patient: Burt, Ronald  
ID#: N60788  
DOB: 1/17/67  
Ordered by: Dr. Nwaobasi  
Menard Correctional Center

CERVICAL SPINE THREE VIEWS 12/5/2012

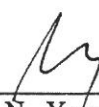
HISTORY: Chronic pain.

FINDINGS: There is narrowing of the disc at C4-C5 level suggestive of degenerative process.

The precervical soft tissues are not thickened and there is no gross evidence of an acute regional bony fracture or dislocation.

The trachea is midline.

Signed

  
N. Yousuf, M.D.

NY:eg  
DIC: 12/6/2012  
Films from Menard Correctional Center

**received**  
12-11-12

M.D. Review

Date 12/11/12  
Doctor N. Yousuf  
Pull Chart \_\_\_\_\_  
See Patient \_\_\_\_\_  
File \_\_\_\_\_

MEN 00697



ILLINOIS DEPARTMENT OF CORRECTIONS  
Offender Health Status Transfer Summary

Transferring Facility:

Mendota Center

Offender Information:

Burt Last Name Ronald First Name MI ID# N60788

Date: 6/8/13 Time: 12 ☒ a.m. ☐ p.m.

Transfer Screening (completed by transferring facility health care staff): ☐ HIV Test & Counseling Offered (only transfers to ATC, parole, release or discharge)

Allergies: NKDA Food Handler Approved: 1-8-13

Current / Acute Conditions / Problems: 0

Chronic Conditions / Problems: Hep. C+

Current Medications (name, dosage, frequency and duration):

Acute Short-term: 0

Chronic Long-term: 0

Chronic Psychotropic: 0

Current Treatments: 0

Therapeutic Diets: 0

Follow-Up Care: 0

Chronic Clinics: Hep. C cc

Specialty Referrals: 0

Significant Medical History: Schizophrenia, (L) pneumonia '85, (R) knee reconstruction '97

Physical Disabilities / Limitations: 0

Assistive Devices / Prosthetics: 0 ☐ Glasses ☐ Dentures

Mental Health Issues: ☐ Hx Suicide Attempt Date: 1/1/13 ☐ Hx Psych Med ☐ Hx MPC / STC Substance Abuse: ☒ Alcohol ☒ Drugs

R & C Use Only: ☒ LAB ☐ EKG ☐ CXR ☐ Dental ☐ MEDS ☐ MH ☐ Other ☐ Patient Complete

L. G. Galt Print Name and Title Burt Signature 6.8.13 Date

Reception Screening (completed by receiving facility health care staff):

Facility: Stateville/WRC Date: 6.12.13 Time: 0 ☐ a.m. ☐ p.m.

Subjective: NK Assessment: No open sores

Current Complaint: NK or wounds

Current Medications/Treatment: None FHA

Objective: 0

Physical Appearance/Behavior: 0

Deformities: Acute/Chronic: 0

T: not medically indicated Plan: Disposition: ☒ Health Information Given ☐ Emergency Referral:

P: 0 ☐ Sick Call: Urgent / Routine

R: 0 ☐ Medication Evaluation ☐ Therapeutic Diet ☐ Special Housing ☒ Chronic Clinics

B/P: 0 ☐ Work / Program Limitation ☐ Specialty Referrals ☐ Other (specify): Hepatitis

0 ☐ Infirmary Placement

0 ☐ HIV Test & Counseling Offered (only transfers from R&C)

0 ☐ Other (specify): 0

0 ☐ Other (specify): 0

0 ☐ Other (specify): 0

For Adult Transition Center transfers only:

I understand that medical and dental care are my responsibility while I am housed in a transition center. I also understand that if I am in need of health care and I cannot afford to pay for it, I may be transferred back into a facility within the Department that can provide my medical, mental health, or dental needs.

Offender's Signature: 0 Date: 0 Time: 0 ☐ a.m. ☐ p.m.

Distribution: Offender's Medical Record; Transferring Facility;  
Receiving Facility

DOC 0090 (Rev. 1/2006)

MEN 01582

BURT SELECTED (MR) 0026

ILLINOIS DEPARTMENT OF OFFENDER  
Offender Health Status Transfer Summary

Transferring Facility:

MRC Center

Offender Information:

Burt  
Last Name

Ronald  
First Name

N60748  
MI ID#

Date: 6/26/13

Time:                      ☐ a.m. ☐ p.m.

Transfer Screening (completed by transferring facility health care staff): ☐ HIV Test & Counseling Offered (only transfers to ATC, parole, release or discharge)

Allergies: NEFA Food Handler Approved: 18-13

Current / Acute Conditions / Problems: D

Chronic Conditions / Problems: Hep C +

Current Medications (name, dosage, frequency, and duration):

Acute Short-term:                     

Chronic Long-term:                     

Chronic Psychotropic:                     

Current Treatments:                     

Therapeutic Diets:                     

Follow-Up Care:                     

Chronic Clinics: Hep C CC

Specialty Referrals:                     

Significant Medical History: Scoliosis (L) prostatic (5 R) knee re-construct 97

Physical Disabilities / Limitations:                     

Assistive Devices / Prosthetics:                      ☐ Glasses ☐ Dentures ☐ Hearing Aid

Mental Health Issues: ☐ Hx Suicide Attempt Date:                      ☐ Hx Psych Med ☐ Hx MPC / STC Substance Abuse: ☒ Alcohol ☒ Drugs

R & C Use Only: ☐ LAB ☐ EKG ☐ CXR ☐ Dental ☐ MEDS ☐ MH ☐ Other:                      ☐ Packet Complete

Bononim RM  
Print Name and Title

[Signature]  
Signature

6/26/13  
Date

Reception Screening (completed by receiving facility health care staff):

Facility: MCC Date: 06/26/13 Time: 5 ☐ a.m. ☒ p.m.

Subjective:                      Assessment: Alert & oriented x3

Current Complaint: none voiced resp even & unlabored

Current Medications/Treatment: see above skin warm dry intact

slow steady gait

Objective:                      Plan: Disposition: ☐ Health Information Given ☐ Emergency Referral:                     

Physical Appearance/Behavior: well nourished ☒ Sick Call: Urgent / Routine

appropriate behavior ☐ Medication Evaluation ☐ Therapeutic Diet ☐ Special Housing ☐ Chronic Clinics

Deformities: Acute/Chronic: none ☐ Work / Program Limitation ☐ Specialty Referrals ☐ Other (specify):                     

986 P: 118 R: 18 B/P: 130/76 ☐ Infirmary Placement:                     

                     ☐ Other (specify):                     

Horn  
Print Name and Title

[Signature]  
Signature

06/26/13  
Date

For Adult Transition Center transfers only:

I understand that medical and dental care are my responsibility while I am housed in a transition center. I also understand that if I am in need of health care and I cannot afford to pay for it, I may be transferred back into a facility within the Department that can provide my medical, mental health, or dental needs.

Offender's Signature

Date

Time

☐ a.m. ☐ p.m.

Distribution: Offender's Medical Record; Transferring Facility; Receiving Facility

DOC 0030 (Rev. 11/2012)

MEN 01583

BURT SELECTED (MR) 0027



ILLINOIS DEPARTMENT OF CORRECTIONS

Offender Outpatient Progress Notes

Mena Center

Offender Information:

Burt Ronald Neot88  
Last Name First Name MI ID#

Date/Time	Subjective, Objective, Assessment	Plans
7-17-13	NP NOTE	P) <sup>①</sup> Referral to
8 <sup>50</sup> AM	S) F/U 12/1 "BACK Pain"	for shearing
100/70	O) Xray results - discussed 12/12	for lubri derm
P 68	Chronic back pain	request.
R 16	Straight leg raise is diff	② Motrin 400mg
98°	Bends well @ waist	i P & TIO PKN
	% of skin rash —	x4 mos. —
	No rash seen 7/17/13	
	A) Chronic back Pain	M. MOJENHAUER RN NP-C
		7/17/13
		905 AM
		with
		with
7/24/13	Rn Note	P) Recall
200	S: B	
	O: on mdc Back pain	
	out of time not seen.	Sheet re
	A) mdc	

Distribution: Offender's Medical Record

Printed on Recycled Paper

DOC 0084 (Eff. 9/2002)  
(Replaces DC 7147)

MEN 01589

BURT SELECTED (MR) 0028

Offender Outpatient Progress Notes

*Wende*

Center

Offender Information:

*Burt*  
Last Name

*Ronald*  
First Name

MI

ID#: *N60788*

Date/Time	Subjective, Objective, Assessment	Plans
8/1/13	MD note	
1 pm	S. Blue hair for FWS of low back pain since 1980s. NOS religious & ASDs O. TTS 4 P18 R/L BP 98/60 5/15 A. 3. NAD note 5/5 OARS 2x SURE A. Chronic low back pain & normal exam.	No indication for Intubation Continue therapy as ordered. FN pm
	<i>Wende</i>	
	<i>RN note:</i>	
9-13-13 640P	S: Scheduled For Court Writ O: No Apparent Medical Procedures Pending A: Physically Stable P: Proceed With Writ	

Distribution: Offender's Medical Record

Printed on Recycled Paper

DOC 0084 (Eff. 8/2002  
(Replaces DC 7147)

MEN 01590



ILLINOIS DEPARTMENT OF OFFENDER  
Offender Health Status Transfer Summary

Transferring Facility:

Stateville

Center

Offender Information:

Burt

Ronald

N 60788

ID#:

Date: 10, 1, 13

Time:

2:15

☐ a.m. ☒ p.m.

Transfer Screening (completed by transferring facility health care staff): ☐ HIV Test & Counseling Offered (only transfers to ATC, parole, release or discharge)

Allergies: N/A

Food Handler Approved: C

Current / Acute Conditions / Problems:

Chronic Conditions / Problems:

hep C (+thrombocytopenia 2nd to Tx of hep C)

Current Medications (name, dosage, frequency, and duration):

Acute Short-term:

Chronic Long-term:

Chronic Psychotropic:

Current Treatments:

Therapeutic Diets:

Follow-Up Care:

Chronic Clinics:

Specialty Referrals:

Significant Medical History:

Scoliosis; Rt Knee reconstructive surg. Lt pneumonia

Physical Disabilities / Limitations:

Assistive Devices / Prosthetics:

Mental Health Issues: ☐ Hx Suicide Attempt Date: 1984

☐ Hx Psych Med

☐ Hx MPC / STC

Substance Abuse: ☒ Alcohol ☒ Drugs

R & C Use Only:

☐ LAB

☐ EKG

☐ CXR

☐ Dental

☐ MEDS

☐ MH

☐ Other:

☒ Packet Complete

M. Mikaitis

M. Mikaitis

10, 1, 13

Print Name and Title

Signature

Date

Reception Screening (completed by receiving facility health care staff):

Facility: Menard Corr. Center

Date: 10, 02, 13

Time: 5:00

☒ a.m. ☐ p.m.

Subjective:

Current Complaint:

Current Medications/Treatment:

Assessment:

Alert & oriented. Resp. unlabored. No cp or any pain or discomfort noted by inmate.

Objective:

Physical Appearance/Behavior:

Well groomed white male. Appropriate answers to questions.

Deformities: Acute/Chronic:

None noted

T: 98.2 P: 72 R: 16 B/P: 110/70

Plan: Disposition:

☒ Health Information Given

☐ Emergency Referral:

☒ Sick Call: Urgent / Routine

☐ Medication Evaluation

☐ Therapeutic Diet

☐ Special Housing

☒ Chronic Clinics

☐ Work / Program Limitation

☐ Specialty Referrals

☐ Other (specify):

☐ Infirmary Placement:

☐ Other (specify):

Martha M. Oakley

Martha M. Oakley

10, 02, 13

Printed Name and Title

Signature

Date

For Adult Transition Center transfers only:

I understand that medical and dental care are my responsibility while I am housed in a transition center. I also understand that if I am in need of health care and I cannot afford to pay for it, I may be transferred back into a facility within the Department that can provide my medical, mental health, or dental needs.

Offenders Signature

Date

Time

☐ a.m. ☐ p.m.

Distribution: Offender's Medical Record; Transferring Facility; Receiving Facility

DOC 0090 (Rev. 11/2012)

MEN 01591

BURT SELECTED (MR) 0030



ILLINOIS DEPARTMENT OF CORRECTIONS  
Offender Health Status Transfer Summary

Transferring Facility:

Center

Date: 9.13.13

Time: ☐ a.m. ☐ p.m.

Offender Information:

Burt

Ronald

Last Name

First Name

MI

ID#: 160788

Transfer Screening (completed by transferring facility health care staff): ☐ HIV Test & Counseling Offered (only transfers to ATC, parole, release or discharge)

Allergies: None Food Handler Approved:

Current / Acute Conditions / Problems:

Chronic Conditions / Problems: hep C

Current Medications (name, dosage, frequency and duration):

Acute Short-term:

Chronic Long-term:

Chronic Psychotropic:

Current Treatments:

Therapeutic Diet: Regular

Follow-Up Care:

Chronic Clinics: hep C (hep C tx stopped D/t thrombocytopenia 2° to hep Rx)

Specialty Referrals:

Significant Medical History:

Physical Disabilities / Limitations:

Assistive Devices / Prosthetics:

Mental Health Issues: ☐ Hx Suicide Attempt Date: 1984

☐ Hx Psych Med

☐ Hx MPC / STC

Substance Abuse: ☒ Alcohol ☒ Drugs

3 C Use Only: ☐ LAB ☐ EKG ☐ CXR ☐ Dental ☐ MEDS ☐ MH ☐ Other:

☐ Patient Complete

Print Name and Title

Signature

Date

Reception Screening (completed by receiving facility health care staff):

Facility: STARKVILLE

Date: 9.18.13

Time: 6 PM

☐ a.m. ☐ p.m.

Subjective:

Current Complaint: SEE ABOVE

Assessment:

DENTAL LESIONS  
PHA

Current Medications/Treatment: ESSENTIAL MEDS

Objective:

Physical Appearance/Behavior: A+ OX3

Plan/Disposition:

☒ Health Information Given

☐ Emergency Referral:

☒ Sick Call: Urgent / Routine

☐ Medication Evaluation

☐ Therapeutic Diet

☐ Special Housing

☐ Chronic Clinics

☐ Work / Program Limitation

☐ Specialty Referrals

☐ Other (specify):

☐ Infirmary Placement:

☐ HIV Test & Counseling Offered (only transfers from R&C)

☐ Other (specify):

Deformities: Acute/Chronic:

T: 98.6 P: 77 R: 16 B/P: 120, 91

Printed Name and Title

Signature

Date

For Adult Transition Center transfers only:

I understand that medical and dental care are my responsibility while I am housed in a transition center. I also understand that if I am in need of health care and I cannot afford to pay for it, I may be transferred back into a facility within the Department that can provide my medical, mental health, or dental needs.

Offender's Signature

Date

Time

☐ a.m. ☐ p.m.

Distribution: Offender's Medical Record; Transferring Facility;  
Receiving Facility

DOC 0090 (Rev. 1/2006)

MEN 01592

BURT SELECTED (MR) 0031

ILLINOIS DEPARTMENT OF CORRECTIONS  
Offender Outpatient Progress Notes

MENARD CORRECTIONAL Center

Offender Information:

BURT

Last Name

Ronald

First Name

Mt

ID#:

N60788

Date/Time	Subjective, Objective, Assessment	Plans
11/26/13	Nurse/CMT Tx Protocol: BACK PAIN	
8:50 AM	Cont. BACK PAIN	<p><b>PX Refer to MD if:</b> <u>OR-GOING BACK PAIN</u>  Abnormal vital signs, temp greater than 100  <u>NECK PAIN REQUEST</u>  <u>RK. RATION.</u></p>
	Rate the pain (1-10) <u>10+</u> Cause of pain? <u>'87-'88 BROKE NECK</u>	Loss of sensation or numbness, Foot drop Difficulty ambulating
	Was the pain immediate or delayed? <u>immediate</u> <u>&amp; PRIOR</u> For how long? <u>ON GOING</u>	<u>Severe pain</u> , or accompanied by Abdominal pain Dark or bloody urine
	Location and pattern (radiation) what worsens / eliminates? <u>NECK - RADIATES TO LBP, constant burning</u>	No improvement after 48 hour trial of Treatment protocol
	Color of urine: <u>WNC</u> Frequency? <u>WNC</u> Any pain on urination? <u>NO</u>	<b>When no MD referral:</b>
	How severe (wake you up at night, elevated with cough)? <u>WAKES YOU AT NIGHT</u> Range of motion? <u>NO</u>	Ibuprofen 200 mg, 1-2 TID PRN with Meals X 3 days. Or Acetaminophen 325 mg., up to 3 tabs TID PRN for up to 3 days
	Fever, chills, night sweats, dysuria: <u>NO</u> Increase in pain with cough? <u>NO</u>	Avoid sporting activities until pain has been gone for at least two weeks Bed rest if necessary for up to 48 hrs PRN
	Are you taking any medications? <u>MOTRIN</u>	Begin gentle strengthening exercises as early as possible and observe proper lifting techniques. (provide exercise packet) No lifting X 5 days,
o)		<b>Patient Teaching:</b>
	T 97.4 P 76 R 20 BP 120/80 Wt 156/lbs.	<input checked="" type="checkbox"/> If injury could have been prevented, instruct on safety measures <input checked="" type="checkbox"/> Proper body mechanics
	Limitation with movement? <u>NO</u> "Doesn't understand how can move & pain." Gait disturbance: <u>POPPING IN HIPS &amp; AMBULATION</u> Any change from sitting to standing? <u>NO</u>	<input checked="" type="checkbox"/> Avoid weight lifting, strenuous activity (Sports restriction) <input checked="" type="checkbox"/> Back exercises when indicated by MD <input checked="" type="checkbox"/> Recommend moist heat, e.g. warm shower when available.
	Swelling, redness, bruises, tenderness to touch, limitation to movement? <u>NO</u>	- Allow 48 hours of trial with simple analgesic. Return to sick call if symptoms persist or worsen.
	Distress or pain with movement? <u>PAIN &amp; WRITING AT WORK - STATIONARY</u> <u>NO, DENIES PAIN &amp; LIFTING</u>	\$2.00 Co-Pay received \$5.00 - <u>420</u>
	A) BACK PAIN	<u>Stamby, RN</u>

Distribution: Offender's Medical Record

DOC 0084 (EH 9/2002  
(Replaces DC 7147)

MEN 01595

BURT SELECTED (MR) 0032



ILLINOIS DEPARTMENT OF CORRECTIONS

Authorization for Release of Offender Medical Health Information

This Authorization may not be used for mental health or substance abuse treatment information (use form DOC 0240)

The Department of Corrections will not condition treatment on this authorization. If authorizing disclosure to persons or organizations that are not health plans, covered health care providers or health care clearinghouses subject to federal health information privacy laws, they may further disclose the protected health information. However, genetic testing or HIV/AIDS information disclosed pursuant to this authorization may not be further disclosed except pursuant to authorization.

I hereby authorize Menard Correctional Center to release the following information: (State Facility)  
specific medical health information to be disclosed including date(s) or date range) new Med Dir R. Caldwell ordered new X-ray 11/30/13 for germa.  
a COPY OF it also + diagnosis results.  
I need all records on My Neck for 2011 (Don't remember the Dates) I need all of them  
From 2012 too including 11/02/12 - 11/03/12 - 12/01/12 on ordering X-ray  
and 12/05/12 day X-RAY completed, I need a copy of the X-ray & I need a  
copy of X-ray results which was months from date done on 12/05/12 & I ne  
all records for 2013 on Neck Dr. visits & go back to 2007 Jan + all way 2013 No  
I need copy of X-RAY/X-ray results first, they are a must have 12/05/13 after done from 11/12  
☒ At Request of Offender and/or: I want them for personal records & because I will receive  
it from me! Purpose of disclosure

from the records of N60788 Burt, Ronald  
ID# Print Offender's Name

to: ☒ Self ☐ Authorized Attorney ☐ Health Care Facility ☐ Other: \_\_\_\_\_

Name: Ronald Burt #N-60788  
Print Name

Address: P.O. Box 1000 - M.C.C.  
Menard, IL 62259  
City State Zip Code

I hereby release and hold harmless, the State of Illinois, the Department of Corrections, and its employees from any liability which may occur as a result of the disclosure or dissemination of the records or information contained therein resulting from the access permitted to the authorized attorney, health care facility, other as specified, or self. Records disclosed may contain confidential medical information including HIV disease information. I understand that I have the right to revoke this authorization at any time prior to disclosure by giving written notice (witnessed by someone who knows my identity) to the primary medical officer. **RECEIVED**

Expiration: This authorization will expire (complete one):

- ☒ 45 days from date of signature  
☐ Upon the occurrence of the following event (must relate to the individual or purpose of the authorization):  
\_\_\_\_\_

Signature:

Ronald E. Burt  
Signature of Offender or Person Authorized to Consent

Relationship

Nov 30, 2013  
Date

\* mailed on 12/20/13

Give Offender a copy if DOC made the request for release.

Distribution: Offender's Medical File

Printed on Recycled Paper

DOC 0241 (Rev. 01/2005)



ILLINOIS DEPARTMENT OF CORRECTIONS  
Offender Outpatient Progress Notes

MCC

Center

Offender Information:

Burt

Ronald

ID#:

1760788

Last Name

First Name

MI

Date/Time	Subjective, Objective, Assessment	Plans
11/30/13 1:15 wt. 150	③ Patient on 50% back pain from old motorcycle accident. Accident was 1988	① x-ray thoracic and lumbar. ③ Motor 20% b-12 90% ② encourage R.O.M. exercise
11/30/13 P 74 R 10	① vitals stable, R.O.M. good back twinges pain - ② Arthroscopy	
11/30/13		Colchicine
11/30/13 7:20 pm	R.N. Note: <sup>envelope</sup> <del>Letter</del> Letter Written S) I have requested medical records to be copied no response. I have requested to be given new Hep C TX again never called again. I was supposed to be seen automatically for my chronic spinal pain and spinal problem this hasn't happened.	P) Emailed Medical Records Anita Rodgers is make request for medical records Emailed Chronic clinic nurse re Hep C TX. I'm seen by medical practitioner on 11/30/13
	OIA) Letter Response	Angela

Distribution: Offender's Medical Record

Printed on Recycled Paper

DOC 0084 (Eff. 8/2002)  
(Replaces DC 7147)

MEN 01596

BURT SELECTED (MR) 0034

ILLINOIS DEPARTMENT OF CORRECTIONS

Offender Outpatient Progress Notes

Menard Center

Offender Information:

Burt Ronald ID#: N60788  
Last Name First Name MI

Date/Time	Subjective, Objective, Assessment	Plans
12/4/13	Xray note	
10 <sup>A</sup>	dorsal + lumbar spine done	Blumppert RTH
	Lab Note	
12-4-13	HCV 1-14 PE 1-14	
818A	RC <u>Connell</u>	
12/19/13	RN Note - Grievance	
6 <sup>25</sup> <sub>P</sub>	S) "I was charged a \$5.00 copay for sick call. I have chronic neck pain and I should not be charged. DIA) Grievance Response	P) I'm responsible for NSC \$5.00 copay unless seen for HPC. I'm scheduled for F/U of 11/30/13 doctor visit to review xray and assessment script for MDOBIL <u>Angie Claus</u>

Distribution: Offender's Medical Record

Printed on Recycled Paper

DOC 0084 (Eff. 9/2002  
(Replaces DC 7147)

MEN 01597

BURT SELECTED (MR) 0035



OneRadiology  
Normal, IL 61761  
Date: December 6, 2013

Patient: Burt, Ronald  
ID#: N60788  
DOB: 1/17/67  
Ordered by: Matticks  
Menard Correctional Center

THORACIC SPINE THREE VIEWS 12/4/2013 ✓  
LUMBAR SPINE THREE VIEWS 12/4/2013

HISTORY: Chronic pain.

FINDINGS: Three views of the thoracic spine demonstrate no compression fracture or  
subluxation.

Three views of the lumbar spine demonstrate minor degree of degenerative change at L5-S1  
level.

There is no compression fracture or subluxation.

There is no spondylolysis or spondylolisthesis.

Signed \_\_\_\_\_  
N. Yousuf, M.D.

NY:eg  
DIC: 12/6/2013  
Films from Menard Correctional Center

M.D. Review  
Date 12-11-13  
Doctor [Signature]  
Pull Chart  
See Patient  
File

12-11-13

OneRadiology  
Normal, IL 61761  
Date: December 6, 2013

Patient: Burt, Ronald  
ID#: N60788  
DOB: 1/17/67  
Ordered by: Matticks  
Menard Correctional Center

THORACIC SPINE THREE VIEWS 12/4/2013  
LUMBAR SPINE THREE VIEWS 12/4/2013

HISTORY: Chronic pain.

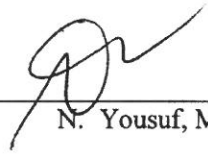
FINDINGS: Three views of the thoracic spine demonstrate no compression fracture or  
subluxation.

Three views of the lumbar spine demonstrate minor degree of degenerative change at L5-S1  
level.

There is no compression fracture or subluxation.

There is no spondylolysis or spondylolisthesis.

Signed \_\_\_\_\_

  
N. Yousuf, M.D.

NY:eg  
DIC: 12/6/2013  
Films from Menard Correctional Center

**received**  
12-11-13

M.D. Review  
Date 12-11-13  
Doctor [Signature]  
Pull Chart         
See Patient         
File       

MEN 00698



ILLINOIS DEPARTMENT OF CORRECTIONS

Offender Outpatient Progress Notes

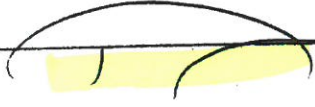
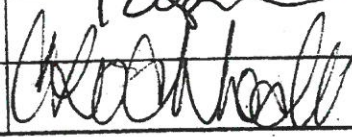
Menard CC Center

Offender Information:

Burt  
Last Name

Ronald  
First Name

ID# NL00188  
MI

Date/Time	Subjective, Objective, Assessment	Plans
12/20/13 1000am	Medical Records Note: Requested records were mailed on this date.	A. Rodgers, PhD/Med
12/24/13 1045	MD note 5' op cervical pain α alert, in MD neck pain noted c-spine some mild narrowing C4-5 Ac degenerative disease C4-C5	P. Exercises Minoxicon PRN as written  Trost noted Shlaumann 12/27/13 1200pm 
12/31/13 9:45a	OPTOMETRY NOTE SEE IDOC 0081	

Distribution: Offender's Medical Record

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DOC 0084 (Rev. 9/2002)  
(Replaces DC 7147)

MEN 01598

BURT SELECTED (MR) 0038

2yri PE

ILLINOIS DEPARTMENT OF CORRECTIONS  
Offender Medical History  
Menard Correctional Center  
Facility

HIV Opt-Out:  
☐ Test  
☐ Refused  
☐ Reception History  
☒ Periodic History

Date: 1/24/14  
Time: 9:15 ☒ a.m. ☐ p.m.

Offender Information:  
Last Name: Burt First Name: Ronald MI: E. ID#: NS0788  
Race: ☒ White ☐ African American ☐ Asian American ☐ Hispanic ☐ Native American ☐ Other  
Gender: ☒ Male ☐ Female Date of Birth: 1/17/67

Subjective:	Past Medical History / History of Present Illness / Family History		Family History	Explanation
Condition	Yes	No		
Allergies	<input checked="" type="checkbox"/>	<input type="checkbox"/>		ASA
Smoking	<input type="checkbox"/>	<input checked="" type="checkbox"/>		
Pediculosis	<input type="checkbox"/>	<input checked="" type="checkbox"/>		
Seizures	<input type="checkbox"/>	<input checked="" type="checkbox"/>		
Asthma	<input type="checkbox"/>	<input checked="" type="checkbox"/>		
Cardiac/HTN	<input type="checkbox"/>	<input checked="" type="checkbox"/>		
Diabetic	<input type="checkbox"/>	<input checked="" type="checkbox"/>		
Disability (vision, hearing, etc.)	<input type="checkbox"/>	<input checked="" type="checkbox"/>		glasses
Communicable Disease				HEU post tx
a. Hepatitis/Jaundice	<input checked="" type="checkbox"/>	<input type="checkbox"/>		
b. Hx + PPD/Active TB	<input type="checkbox"/>	<input checked="" type="checkbox"/>		
c. STD	<input type="checkbox"/>	<input checked="" type="checkbox"/>		
d. HIV +/- AIDS	<input type="checkbox"/>	<input checked="" type="checkbox"/>		
Surgeries	<input type="checkbox"/>	<input checked="" type="checkbox"/>		2 knee rebuilt 9/6 or 97
Hx of Psych Tx	<input type="checkbox"/>	<input checked="" type="checkbox"/>		
a. Past Suicide Attempt	<input type="checkbox"/>	<input checked="" type="checkbox"/>		
b. Current Suicidal Ideation	<input type="checkbox"/>	<input checked="" type="checkbox"/>		
Recent Drug/ETOH use	<input type="checkbox"/>	<input checked="" type="checkbox"/>		
Mobility Problems				
a. Assistive Devices	<input type="checkbox"/>	<input checked="" type="checkbox"/>		
b. Prosthetics	<input type="checkbox"/>	<input checked="" type="checkbox"/>		
c. Specialized Equipment	<input type="checkbox"/>	<input checked="" type="checkbox"/>		
Other Medications	<input checked="" type="checkbox"/>	<input type="checkbox"/>		Mobic - c spine
History of Sexual Abuse or Predator	<input type="checkbox"/>	<input checked="" type="checkbox"/>		
Oriented x3	<input checked="" type="checkbox"/>	<input type="checkbox"/>		
Other:	<input type="checkbox"/>	<input checked="" type="checkbox"/>		

Objective: T: 98.4 P: 84 ☒ regular ☐ irregular R: 116 ☒ regular ☐ irregular BP: 134/94  
Height: 6'3" Weight: 150 Vision: RT 20/ 25 LT 20/ 25 Corrected: RT 20/ 25 LT 20/ 25

Behavioral appearance. Hearing loss. Mental status. Evidence of deformity, trauma, and skin conditions. Cooperative - d hearing loss.  
Stable - d deformity or trauma. Denies rash. States has "sore/cyst" pubic area.

Assessment: A+D x3. Stable white male.  
1. Allergy: ASA  
2. glasses  
3. HEU  
4. Psych Hx

Plan: (Check and complete as appropriate)

- Physical Examination: ☐ Urgent ☒ Routine
- Mental Health Referral: ☐ Urgent ☒ Routine
- Health Information Given: ☒ Yes ☐ Refused
- PPD Results: Screen ☐ Positive ☐ Negative
- Chest X-ray performed: ☒ N/A ☐ Yes ☐ No
- Other: NA

TB screen done 1/17/14 B.Hern

Date PPD Administered: 1/17/14 Date PPD Read: 1/17/14  
Reading: 0 mm By: B.Hern

H.Medchee CMT  
Print Name of Interviewer

H.Medchee CMT  
Signature

R & C Use Only			
LAB:	Sickle Cell: <input type="checkbox"/> Yes <input type="checkbox"/> No	Dental:	Panorex:
EKG:	CXR:	Female Only:	PAP:
			Mamo:

Distribution: Offender's Medical Record

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DOC 0092 (Rev. 11/2012)

MEN 01490

BURT SELECTED (MR) 0039



ILLINOIS DEPARTMENT OF CORRECTIONS

Offender Outpatient Progress Notes

MCCi

Center

Offender Information:

Burt

Last Name

Ronald

First Name

E.

MI

ID#

N00708

Date/Time	Subjective, Objective, Assessment	Plans
	<p>1st RN Note / CMT Note</p> <p>2nd Date: 3/19/14 Time: 3p</p> <p>3rd Tubersol 0.1cc Intradermal Left Forearm</p> <p>4th LOT: C4511A</p> <p>5th Expiration Date: 5/21/16</p> <p>6th Given By: Hengle, J. C.</p>	
3.21.14 7:50 pm	<p>RN Note</p> <p>S "The patient states presented helped fight the inflammation</p>	Refer to MD for next pain evaluation
11:18 / 7:16 8:4	<p>seal can remove, but elt</p> <p>doesn't take the pain away</p>	
20 98.4	<p>the following things that helped:</p> <p>1) the present pain in the L shoulder area 4/10 sharp stabbing pain 7 on a scale of 10. Discomfort higher than (R) pain upon preparation to cervical</p> <p>muscle 3 radiating from top of cervical area to shoulder. Not shown.</p>	
	<p>2) All in Comfort</p>	

Distribution: Offender's Medical Record

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DOC 0084 (Rev. 9/2002)  
(Replaces DC 7147)



**ILLINOIS DEPARTMENT OF CORRECTIONS**  
**Offender Outpatient Progress Notes**

Mena

Center

**Offender Information:**

Burt

Last Name

Ronald

First Name:

E

M

ID#:

NG0788

Date/Time	Subjective, Objective, Assessment	Plans
3/27/14	MD note	
1330	SE Relief to neck	
50	OL neck to Rowl	
98	OL osteoarthritis cervical spine	
126/72		
72		
14		
		medic 7.5mg PO BID PRN X 6mo
		Trust
		Noted Trust 3/27/14 1:00 PM

**Distribution: Offender's Medical Record**

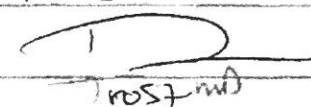
*Printed on Recycled Paper*

DOC 0084 (Eff. 9/2002  
(Replaces DC 7147))

ILLINOIS DEPARTMENT OF CORRECTIONS  
Offender Outpatient Progress Notes

Center

Offender Information:			
Burt	Ronald	MI	ID#: N60788
<small>Last Name</small>	<small>First Name</small>	<small>MI</small>	

Date/Time	Subjective, Objective, Assessment	Plans
4/6/14	MR note	
	S'gs weakness/tingling @	
	leg x 3 days & other symptoms	
	OK about, in MR	
	VSS. Neurologic intact.	
	Ambulates well.	
	A: @ leg ortho per.	P:
		PTC 1 wk
		
		10/16/10 10/16/10

Distribution: Offender's Medical Record

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DOC 0084 (Eff. 8/2002)  
(Replaces DC 7147)



ILLINOIS DEPARTMENT OF CORRECTIONS

Offender Outpatient Progress Notes

Menard Carr Center

Offender Information:

Burt Ronald ID#: N60788  
Last Name First Name MI

Date/Time	Subjective, Objective, Assessment	Plans
10-10-14 30 1 pm	R.N. NOYE S- C/O co-pay = chronic pain D- 9-25-14 Refused USC due to co-pay. 10-6-14 USC for numbness/tingling Rt leg → refers to MD & seen @ FH in wk A-Grievance Response	B- FH i wk Conduct Rn X-ray of L-S spine to compare & 12/4/13.
10/14/14 11:55	S- th. for numbness & tingling "like my leg is asleep" X1 med.	R/R 2 med.
Apr 47 11/6/84 82)	Started while he was walking; got dizzy & disoriented that same day. H of mini O/D	11/5
16 pm. 77.20	LS- SI. + hyp. CV O- Good steady gait Neurologically intact	

Distribution: Offender's Medical Record

Printed on Recycled Paper

DOC 0084 (Eff. 9/2002  
(Replaces DC 7147)





ONE RADIOLOGY  
Normal, IL 61761  
Date: October 17, 2014

PATIENT: Burt, Ronald  
ID#: N60788  
DOB: 1/17/67  
Ordered by: Dr. Fuentes  
Menard Correctional Center

LUMBAR SPINE THREE VIEWS 10/16/2014

HISTORY: Numbness of the right leg.

FINDINGS:  
There is mild degenerative disc disease at L5-S1 level.

No compression fracture or subluxation is seen.

Signed

  
N. Yousuf, M.D.

NY:eg  
DIC: 10/17/2014  
Films from Menard Correctional Center

M.D. Review

Date 10/22/14

Doctor [Signature]

Pull Chart [Signature]

See Patient [Signature]

Received  
10-22-14

ILLINOIS DEPARTMENT OF CORRECTIONS  
Offender Outpatient Progress Notes

Center

## Offender Information:

Bout  
Last Name

First Name Ron

ID#: N 60785

Date/Time	Subjective, Objective, Assessment	Plans
10/28/14 1150P T-953 H.151 120/84 PCR R14	y.O.v.b S - stui & pairs are the front area, "unbearable" at times. O - Attene Gone Hedy gain. X-ray of L-S spine - mild degener. changes L5-S1. A - D/D lumbar	hyperaer 5W mg T Birds per x 2 mints. R52 per L5-S1 Fender 12/14

Distribution: Offender's Medical Record

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DOC 0084 (Eff. 9/2002  
(Replaces DC 7147))





## Initial Hepatitis Work Sheet - Illinois

Name: Burt, Ronald Date: 5/8/14 Time: \_\_\_\_\_  
 ID Number: N160788 Institution: Menard CC DOB/Age: 1-17-67 / 47

### NURSING ASSESSMENT:

Allergies: NKDA MSR/Outdate: Life  
 Sex: ☒ Male ☐ Female Race: ☒ Caucasian ☐ African American ☐ Hispanic ☐ Asian  
 Intravenous Drug Use: Yes ☒ No ☐ Date Started: 1980 Date Ended: 1998 Drugs: Cocaine + Heroin  
 Alcohol consumption: Yes ☐ No ☒ Date Started: \_\_\_\_\_ Date Ended: \_\_\_\_\_ Avg Drinks Per Day: \_\_\_\_\_  
 Tattooing: Yes ☒ No ☐ Multiple Sex Partners: Yes ☒ No ☐ Partner with known Hep B/C: Yes ☐ No ☒  
 Previous Dx of Hep B/C: Yes ☒ No ☐ Date of Dx: 2000 Previous Dx HIV: Yes ☐ No ☒ Date: \_\_\_\_\_  
 Hemodialysis: Yes ☐ No ☒ Blood Tx prior to 1992: Yes ☒ No ☐ Date: \_\_\_\_\_ Other: \_\_\_\_\_  
 Episode Jaundice: Yes ☐ No ☒  
 VACCINES: Hep A/B Yes ☒ No ☐ Date Started: Unknown Date Completed: Unknown

Medications: 1. moaic 7.5mg Bid 2. \_\_\_\_\_ 3. \_\_\_\_\_ 4. \_\_\_\_\_  
 5. \_\_\_\_\_ 6. \_\_\_\_\_ 7. \_\_\_\_\_ 8. \_\_\_\_\_

### PROVIDER ASSESSMENT:

#### Comorbidities:

HD: ☐ None ☐ Coronary Heart Dz ☐ Cerebrovascular Disease ☐ COPD ☐ Renal Insufficiency ☐ Diabetes  
☐ Thyroid Disease ☐ Esophageal Varices ☐ Ascites ☐ Upper or Lower GI Bleed ☐ Active PUD ☐ Coagulopathy ☐ Jaundice/Hyperbilirubinemia  
☐ Thrombocytopenia ☐ Anemia ☐ HIV ☐ Connective Tissue Disease ☐ Solid Organ Transplant ☐ Hypertension  
☐ Neuropsychiatric Disorder ☐ Age >50 ☒ Other: Scoliosis

#### \*Stability Status of each Comorbid Illness (should correlate with medications/ comorbidities listed):

1. on moaic for Neck pain (Scoliosis) - medication working
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

\*Example: List HbA1c% if Diabetic, last TSH if thyroid d.o., list mental health med doses and duration on those doses or changes in doses if mental health disorder, CD4 count/ HIV VL if HIV coinfectd, etc.

Studies: Hgb/Hct 14.5 / 45.7 Plts 149 WBC 5.2 ANC 2.8 Date: 12-4-13 PT/INR 1.1 Date: 12-4-13  
 ALT 43 AST 32 Alk Phos 53 Tot Bil/Direct 0.9 / 1.0 Albumin 4.3 Date: 12-4-13  
 Hep A IgG ☐ Pos ☐ Neg Hep Bs Ag ☐ Pos ☐ Neg Hep Bs Ab ☐ Pos ☐ Neg Hep C Ab ☐ Pos ☐ Neg HIV Ab ☐ Pos ☐ Neg

APRI = AST/ULN AST x 100/Platelet Count (10<sup>9</sup>/L) = 0.536 (< 0.50 = Normal)

Previous HCV Genotype/ HCV Viral load testing Date: 1A 3289620 Date: 2/18/10

☒ Previous Liver Biopsy Date: 5/1/8 Result: G3 S2 (Fax Biopsy Report 412-937-9151)

#### Collegial discussion with Hepatitis Coordinator regarding consideration for Hepatitis treatment:

☐ Date/ Time of discussion: \_\_\_\_\_  
☐ Recommendations made: \_\_\_\_\_  
 Recommended Follow-up testing/ labs ordered on date: \_\_\_\_\_

Nurse Signature: [Signature] Date: 5/12/14 Time: \_\_\_\_\_  
 Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

OneRadiology  
Normal, IL 61761  
Date: December 6, 2012

Patient: Burt, Ronald  
ID#: N60788  
DOB: 1/17/67  
Ordered by: Dr. Nwaobasi  
Menard Correctional Center

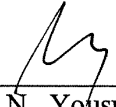
CERVICAL SPINE THREE VIEWS 12/5/2012

HISTORY: Chronic pain.

FINDINGS: There is narrowing of the disc at C4-C5 level suggestive of degenerative process.

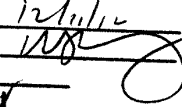
The precervical soft tissues are not thickened and there is no gross evidence of an acute regional bony fracture or dislocation.

The trachea is midline.

Signed \_\_\_\_\_  
N. Yousuf, M.D.

NY:eg  
DIC: 12/6/2012  
Films from Menard Correctional Center

**received**  
12-11-12

M.D. Review  
Date 12/11/12  
Doctor   
Pull Chart \_\_\_\_\_  
See Patient \_\_\_\_\_  
File ✓



ODIE WASHINGTON

Director

Menard Correctional Center / Menard, Illinois 62259-0711 / Telephone (618) 826-5071

PATIENT NAME: *Burt, Ronald*

DATE OF EXAMINATION: *10-24-96*

PATIENT NO.: *160788*

ATTENDING PHYSICIAN: *Khan*

BIRTH DATE: *1-17-67*

INSTITUTION: *Menard CC*

EXAMINATION  
REQUESTED: *C-spine*

RELEVANT  
HISTORY: *C/O Back + Neck pain*

CERVICAL SPINE

There is a mild left convex torticollis centered at C3 and a lower cervical upper thoracic scoliosis convex to the right centered at C6/C7. The prevertebral, predental and intervertebral disc spaces are of normal width. No fracture, spondylolisthesis or destructive changes are identified.

IMPRESSION: NO FRACTURE.

TORTICOLLIS AND SCOLIOSIS.

MICHAEL J. SILBERSTEIN, M.D.  
MJS/sb

X-ray/Lab Report		
Rec'd C-L Off	Date	Initial
	<i>10-28-96</i>	<i>W</i>
Dr. Rev. Eval	Date	
	<i>10/28/98</i>	<i>114</i>
Status per Dr. Order		
Rec'd C-L Off	<input type="checkbox"/>	
Rec'd C-L Off	<input type="checkbox"/>	
C-L Off		
No et. C-L Off	<input checked="" type="checkbox"/>	
Initials C-L Off with Dr. <i>BD</i>		

RADIOLOGIST

MEN 00643